Wasatch INFUSION

888.717.7578 801.577.7055

Open 365 days a year • 8am-8pm

BY APPOINTMENT

KRYSTEXXA® pegloticase

LOCATION

☐ Murray ☐ Tooele

REFERRAL STATUS

☐ New Referral ☐ Order Renewal

PATIENT INFORMATION

PATIENT NAME:		DOB: SEX: ☐ M: ☐ F:	
WEIGHT: ☐ LBS ☐ KG		PHONE #:	
ALLERGIES:		EMAIL:	
Please check that the following are included:	☐ Patient demographics and insurance attached	☐ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached	
	☐ Current Medication List		

DIAGNOSIS

ICD-10 CODE: M10.9 (Gout, unspecified) Other:	Date of last infusion/injection:

PHYSICIAN INFORMATION

Physician Name:	Phone Number:
Practice Name:	Fax Number:
Office Contact:	

MEDICATION ORDER

Medication:	Dosing:	Frequency:	Notes/Comments
Krystexxa	**8mg**	**Every 2 weeks**	

Physician Signature _____ Date (Order is Valid for One Year) _____

LAB ORDERS

☐ G6P-D (Only necessary prior to first Krystexxa infusion)

☐ Uric Acid Frequency: Prior to each Krystexxa infusion

TYPE OF ACCESS

☐ Peripheral ☐ PICC ☐ Midline ☐ Port ☐ Subcu ☐ I/M